VERMONT
AGENCY OF HUMAN SERVICES

Department for Children and Families
Child Development Division
103 South Main Street
Waterbury, VT 05671-2401

CHILD CARE FINANCIAL ASSISTANCE PROGRAM CERTIFICATE			
Certificate #XXXXX			
Payment Start Date	**XX/XX/XXXX**	**Payment End Date**	**XX/XX/XXXX**

[Today's Date]

Parent Name
Mailing Address
City, State, Zip

Provider Name
Mailing Address
City, State, Zip

Dear [insert Parent name],

The Child Development Division (CDD) within the Department for Children and Families has determined you are eligible for child care financial assistance. Payment will be made directly by the CDD to your provider after your provider submits a bill for the services they deliver.

VERY IMPORTANT!

- You may have to pay a co-payment for the difference between the amount covered by this Certificate and the amount your provider charges. (See **cost not covered by Financial Assistance** below), Co-payments are paid directly to your provider.
- Please report any changes that may affect your eligibility as soon as they happen to the Eligibility Specialist listed below. Changes include a change in family income, address, marital status, household size, or employment/training.
- For more information regarding the Child Care Financial Assistance Program visit http://dcf.vermont.gov/cdd/families/pay_child_care

(**Insert name**) is eligible for **(full time/part time or extended time**), at a **(% of the Total State Rate**) benefit. Your provider is (enter provider type) and has (0-5 Stars).For more information on STARS visit http://dcf.vermont.gov/cdd/stars

Provider recorded rate	$XXXXX
Base Rate	$XXXXX
Quality Factor	$ XXXX
Total State Rate	$XXXXX
X% Benefit (total paid by CDD)	**$ XXXX**
Maximum Co-payment amount.	**$XXXXX**

Contact Information

Parent Contact phone:
XXX-XXX-XXXX

Provider Contact Phone:
XXX-XXX-XXXX

Eligibility Specialist: **Telephone #:** XX-XX-XXXX **Email:**

How to Appeal this Decision

If you are not satisfied with this decision, you may request an appeal. Mail your **written request** for an appeal to the CDD at the address on the top of this Certificate. The request for appeal must be sent within 30 days of this letter. The appeal will be reviewed by the Financial Assistance Unit of the CDD. If you are not satisfied with the decision CDD makes, you may then choose to submit a written request for a Fair Hearing by filing an appeal, with the Human Service Board (State Office Building, Montpelier, VT 05602) within 30 days of the Financial Assistance Unit's determination.